PRE-ADMISSION REFERRAL FORM

PRE-ADMISSION REFERRAL FORM PLEASE PROVIDE THIS COMPLETED FORM AND ALL REQUIRED INFORMATION TO OUR SECURE EMAIL TO ONE OF THE FOLLOWING; The OWNER, MAYA ROYCE, MAYA@MyECRC.com; The ADMINISTRATOR HOLLY ROYCE, HOLLY@MyECRC.com; OR The RESIDENTIAL MANAGER, REED BUCKLEY, REED@MyECRC.com, or SEND A SECURE FAX TO 928-255-1741. If you have any questions please call 928-529-3567 and speak to Reed Buckley, our Residential Manager.

ALL REFERRALS WILL BE REVIEWED AND RESPONDED TO WITHIN 24 BUSINESS HOURS

All clients must meet the following criteria for admission and/or readmission into Exclusive Certified Residential Care, LLC:

- Be at least 18 years of age;
- Must be diagnosed with a Mental Health Disorder or Serious Mental Illness;
- Is not required to register as a sexual offender;
- Demonstrate a willingness to participate in treatment;
- Is not in debt to Exclusive Certified Residential Care, LLC;

Date of Referral: _____ **Date of admission requested:** _____

Client Name: _____ **DOB:** ___/___/_____ **Phone Number:** _____

Social Security #: _____

Client AHCCCS ID #: _____

Address (Coinciding with the client AHCCCS ID): _____

_____

Diagnosis Code(s) ICD-10:

_____

_____

SS / SSDI Benefits: _____ **Amount:** $_____ **Food Assistance:** _____**Amount:** $ _____

Payee Contact information: (If applicable)

_____

_____

_____

INDIVIDUAL TO NOTIFY IN CASE OF AN EMERGENCY

Name: _____ **Relationship:** _____**Contact No:** _____

Address: _____

Clients Parent, Guardian, or Custodian: _____ **Phone:** _____

CLIENT'S PCP INFORMATION

Client's Medical PCP Name: _____ **Doctor's Name:** _____

Date of last appointment: _____ r

Phone: _____ **Fax:** _____

Address: _____

PROVIDING AGENCY INFORMATION

Client's Case Manager's Name: _____

Best Contact Phone Number: _____ **Email Address:** _____

Reason for Referral: _____
_____
_____
_____
_____
_____
_____

PHARMACY INFORMATION

Client's Medical PCP Name: _____ **Doctor's Name:** _____

Date of last appointment: _____ **Reason:** _____

Phone: _____ **Fax:** _____

Address: _____

_____

PLEASE PROVIDE EXCLUSIVE CERTIFIED RESIDENTIAL CARE WITH THE FOLLOWING INFORMATION LISTED BELOW WITH THE REFERRAL PACKAGE.

- Current Behavioral Health Treatment Plan. Must be signed by client, Case Manager and BHP. An updated treatment plan including the need for Residential Treatment signed by the Client, Case Manager and BHP within 7 days of admittance to E.C.R.C.

- Current Behavioral Health Crisis Plan. (Within the last 6 mos.)

- Annual Behavioral Health Assessment - (i.e. description of clients' presenting issue; identification of client's behavioral health symptoms and each behavior issue that requires treatment; description of medical symptoms reported by the client and medical referrals needed by the client, if any; recommendations for further assessment or examination of client's needs; recommendations for treatment needed for the client; recommendation for ancillary services or other services needed for the client. The signature, of the professional whom conducted the assessment and the credentials and job title.

- Recommendation for ancillary services or other services needed for the client. The signature, of the professional whom conducted the assessment and the credentials and job title.

- Are there any additional examinations and/or assessments? ◯ **Yes** ◯ **No**
  If yes, please provide with this referral package.

- A copy of the client informed Consent to Treat.

- A copy of documentation signed and dated by client or (if applicable) the clients, parent, guardian or agent indicating receipt of information under R9-10-712

- If the Client is **Title 36**, please include a copy of the court order with this referral, this is ***mandatory***.

- Physical completed by PCP / NP within the last 3 months.
- Documentation of the screening for Infectious Pulmonary Tuberculosis, (TB Test) with a negative result and within the last 6 months.
- Documentation of any allergies, medications, food, other
- Current medication list including psychiatric and PCP prescriptions
- Results from any additional examinations or assessments and/or information or records provided by or obtained from another individual, agency, or entity regarding the client.
- Documentation of necessary assistance to be provided to clients with physical or other applicable disability.
- Documentation of Client's Healthcare Directives, if applicable.
- Upon approval of referral, all the client's medications must include minimum of 30-day supply or a refill available at a local pharmacy.

Person submitting referral:

_____ _____

Printed Name **Date** **Signature** **Date**

Agency: _____

Telephone: _____ **Fax:** _____

Thank you for your referral to E.C.R.C.